560-1
Federal regulations provide, in pertinent part, that:

(b) A state plan must–

(1) Specify a single State agency established or designated to administer or supervise the administration of the plan; and

(2) Include a certification by the State Attorney General, citing the legal authority for the single State agency to–

(i) Administer or supervise the administration of the plan; and

(ii) Make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.

(c) Determination of eligibility. (1) The plan must specify whether the agency that determines eligibility for families and for individuals under 21 is–

(i) The Medicaid agency; or

(ii) The single State agency for the financial assistance program under Title IV-A (in the 50 States or the District of Columbia).

(2) The plan must specify whether the agency that determines eligibility for the aged, blind, or disabled is–

(i) The Medicaid agency;

(ii) The single State agency for the financial assistance program under Title IV-A (in the 50 States or the District of Columbia); or

(iii) The Federal agency administering the supplemental security income program under Title XVI (SSI). In this case, the plan must also specify whether the Medicaid agency or the Title IV-A agency determines eligibility for any groups whose eligibility is not determined by the Federal agency.

(e) Authority of the single State agency. In order for an agency to qualify as the Medicaid agency–

(1) The agency must not delegate, to other than its own officials, authority to–

(i) Exercise administrative discretion in the administration or supervision of the plan, or

(ii) Issue policies, rules, and regulations on program matters.

(2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action

by other offices or agencies of the State.

(3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

(42 Code of Federal Regulations §431.10)

561-1A ADDED 12/04
Individuals eligible to receive PCSP payments must have a chronic disabling condition expected to last 12 months or end in death (§51350(b)); a need for at least one personal care service or paramedical service (§§51350(a) and 51183); a service provider who is not the parent (if a minor) or a spouse (§51181); and must not be receiving advance payment for services (Manual of Policies and Procedures (MPP) §30-780.4).

561-2
Personal care services may be provided only to individuals who would be unable to remain safely at home without the services. (§51350(b))

For purposes of §51350(b), "home" means that place in which the beneficiary chooses to reside.

A person's "home" does not include a board and care facility, a facility licensed by the CDHS, nor a community care facility or a residential care facility licensed by the CDSS. A person receiving an SSI/SSP payment for a nonmedical out-of-home living arrangement is not considered to be living in her or his "home". (§51145.1)

561-2A
The CDHS has defined a "home" as real or personal property, fixed or mobile, located on land or water, in which a person or family lives. (§50044)

561-2B
State law permits PCSP authorization for services "provided in the beneficiary's home and other locations as may be authorized by the director subject to federal approval." (W&IC §14132.95(a)(1))

561-3
Personal care services will be prescribed by a physician. The medical necessity for personal care shall be certified by a licensed physician at least annually. (§51350(c); see also Manual of Policies and Procedures Handbook §30-780.2(e))

As of October 1, 1994, the physician certification requirement (that the medical necessity for personal care had to be certified by a licensed physician at least annually) was eliminated. (All-County Letter No. 94-93, November 4, 1994, modifying §51350(c) based on federal law changes and Senate Bill 1028, Chapter 964, Statutes of 1994)

A licensed physician is one who is authorized to practice in California or a contiguous state, who is a Medi-Cal provider (even if practicing in another state), and osteopathic physicians who meet the above requirements (D.O.s).

A Christian Science practitioner may provide a written statement attesting to the client's belief as a Christian Scientist and the client's need for personal care services. This shall serve in lieu of the physician certification. All other religious practitioners must be approved by the Department of Health Services.

(All-County Letter (ACL) No. 93-67, September 10, 1993)

561-4
An otherwise eligible recipient who refuses to cooperate with the county to complete any required paperwork, including the Physician Certification (SOC 425) and the Provider Enrollment/Certification, or who fails to provide information needed to determine his/her PCSP eligibility and need for service, shall be ineligible for PCSP, and also for services under the residual IHSS Program. It is the county's responsibility to inform the recipient of the responsibility to complete these required forms, to explain the purpose of the forms, and to assist the recipients in obtaining the forms.

If a recipient has cooperated fully, and the doctor fails to complete the necessary documentation; or if a recipient cannot understand his/her reporting responsibility and has been referred for protective services, then the county shall assist the individual in securing a physician's certification or an authorized representative. The individual is not eligible for residual IHSS pending such assistance, but is eligible for retroactive PCSP reimbursement for services subsequently authorized and actually delivered by a qualified provider on or after the date of application.

(All-County Letter (ACL) No. 93-67, September 10, 1993; ACL 94-07, January 25, 1994)

561-5 ADDED 2/05
All Medi-Cal eligibility determinations are to be completed following Medi-Cal rules. This includes Medi-Cal eligibility determinations for the In-Home Supportive Services (IHSS) and Personal Care Service Program recipients. (All County Welfare Director’s Letter 04-27, August 30, 2004)

561-5A ADDED 8/05
Medi-Cal eligibility determinations and redeterminations are to be performed on all applications received by the county requesting in-home services and existing in-home service for persons who are not also eligible for SSI/SSP or other Medi-Cal linked cash-based assistance. These determinations/redeterminations are to be performed by Medi-Cal eligibility workers using Medi-Cal rules, Medi-Cal forms, and notices of action.

Individuals must be determined eligible for whatever Medi-Cal program is appropriate (e.g., Section 1931(b), Aged and Disabled Federal Poverty Level, Pickle, Medically Needy, 250 percent Working Disabled, etc) before a referral is forwarded to the IHSS unit for a needs assessment.

(All County Welfare Director’s Letter 05-21. June 13, 2005).

561-6
It is the position of the CDSS that if an "eligible recipient" (i.e., eligible, per CDHS, because the recipient receives a personal care service and the case is not in advance pay, receiving protective supervision, or the recipient has a spouse/parent provider) refuses to cooperate with the county by failing to complete the form SOC 426, or fails to provide information needed to determine his/her eligibility and need for service, the recipient cannot be authorized PCSP "and will not be eligible for the same services under the residual IHSS program", relying on Welfare & Institutions Code (W&IC) §§12300(f) and 14132.95(a) and (p). The CDSS says that, as stated in §30-757.1, a "PCSP eligible recipient cannot refuse personal care [emphasis added] under PCSP and still receive ancillary services from residual IHSS." (All-County Welfare Directors Letter No. 99-13, March 29, 1999; All-County Letter (ACL) No. 99-25, April 19, 1999)

561-6A
CDSS has stated that state regulations provide that a PCSP eligible recipient cannot refuse personal care under PCSP and still receive ancillary services from IHSS. The regulation cited by the CDSS provides in pertinent part:

"A person who is eligible for a personal care service provided pursuant to the PCSP shall not be eligible for that personal care service through IHSS." [emphasis added] (§30-757.1, cited in All-County Letter No. 99-25, April 19, 1999)

561-7
IHSS recipients with an SOC who were “potentially eligible for PCSP” were sent form SOC 426, and asked to return these forms to the county social services worker within five days.

It is the position of the CDSS (i.e., there have been no regulations issued) that if a recipient understands his/her responsibility and fails to cooperate, the county should issue a courtesy notice of noncompliance, specifying that the recipient must submit the provider enrollment form to the county within fifteen calendar days or lose eligibility for both IHSS and PCSP. At the end of the fifteen-day period, recipients who have not submitted the form should be sent a notice of action informing them that services will be discontinued in 10 days.

(All-County Letter No. 99-25, April 19, 1999)

562-1 REVISED 8/05
A personal care services provider is that individual, county employee or county contracted agency authorized by the Department of Health Services to provide personal care services to eligible beneficiaries. An individual provider shall not be the parent of a minor child or a spouse. (§51181; see also Manual of Policies and Procedures (MPP) Handbook §30-767.3)

A child means a person under the age of 21, except for those considered adults per §50014. (§50030(a)) An unborn is considered a child for Medi-Cal purposes (§50030(b))

562-2
All providers of personal care program services must be approved by the Department of Health Services (DHS) and shall sign the "Personal Care Program Provider/Enrollment

Agreement" form designated by DHS, agreeing to comply with all applicable laws and regulations governing Medi-Cal and personal care service. (§§51483.1 and 51204)

562-3
PCSP beneficiaries shall be given a choice of service provider who meets personal care provider requirements. (51483.1)

The beneficiary, the beneficiary's personal representative or the legal parent or guardian (if the beneficiary is a minor) shall certify on the provider enrollment document that the provider is considered to be qualified to provide personal care. (§51204(a); see also Manual of Policies and Procedures Handbook §30-767.4)

562-4
Contract agency personal care providers shall be selected in accord with Welfare and Institutions Code §12302.1. (§51204(b); see also Manual of Policies and Procedures Handbook §30-767.4(b))

562-5
A provider of personal care services who has a grievance or complaint may initiate an appeal within 90 days of the action precipitating the grievance or complaint to the county department. A provider who is dissatisfied with the decision of the county department may seek judicial remedy pursuant to W&IC 14104.5 (§51015.2; see also MPP Handbook §30-767.5)

563-1
The Personal Care Service Program includes personal care and ancillary services.

Personal care services include:

(1) Assisting with ambulation. Ambulation does not include movement solely for the purpose of exercise.

(2) Bathing and grooming.

(3) Dressing.

(4) Bowel and bladder and menstrual care.

(5) Repositioning, transfer skin care (e.g., rubbing skin and repositioning to promote circulation and prevent skin breakdown) and range of motion exercises.

(6) Feeding, hydration assistance, cleaning face and hands following meal.

(7) Assistance with self-administration of medications.

(8) Respiration, nonmedical services, such as assistance with self-administration of oxygen and cleaning oxygen equipment.

(9) Paramedical services, as defined in Welfare and Institutions Code §12300.1. This includes administration of medications, puncturing the skin, or other

activities requiring judgment based on training given by a licensed health care professional.

Ancillary services are limited to the following and are subject to time-per-task guidelines established in the Manual of Policies and Procedures (MPP). Ancillary services are:

(1) Domestic services.

(2) Laundry services.

(3) Reasonable food shopping and errands limited to the nearest available stores or facilities consistent with the beneficiary's economy and needs. This includes compiling a list, putting items away, phoning in and picking up prescriptions.

(4) Meal preparation and cleanup including planning menus.

(5) Accompanying the beneficiary to and from appointments with health care practitioners, and to the site where alternative resources provide IHSS, when the beneficiary's presence is required at the destination, and no other Medi-Cal service will provide the transportation.

(6) Heavy cleaning, which is thorough cleaning of the home to remove hazardous debris or dirt.

(7) Yard hazard abatement, which is light work in the yard.

(§51183; see also MPP Handbook §30-780.1)

563-1A ADDED 8/05
Protective supervision, and cases that authorize Domestic and Related –Only services, will receive federal funding under PCSP. If there is a parent (for minor child) or spouse provider, or restaurant meal allowance or advance pay, the case is funded under the IHSS Plus Waiver (All County Letter 05-05, June 2, 2005)

563-2
Personal care services, as set forth in §51183, shall be authorized by the county department based on the Uniform Assessment tool. The needs assessment process shall be governed by the Manual of Policies and Procedures (MPP), §§30-760, 30-761 and 30-763, unless inconsistent with the Medi-Cal Program. (§51350(a); see also MPP Handbook §30-780.2(a))

563-3
Personal care services shall not exceed 283 hours in a calendar month. (§51350(b); see also Manual of Policies and Procedures Handbook §30-780.2(b))

There is no dollar maximum limit. (All-County Letter No. 95-42, August 11, 1995)

563-3A
A non-severely impaired individual (as referenced in Manual of Policies and Procedures (MPP) §30-701(s)(1), may receive a maximum of 195 hours per month.

When such an individual receives both protective supervision in the residual IHSS program, and PCSP, that individual may receive up to 195 hours per month of protective supervision, plus all of the PCSP needs, but not in excess of 283 hours per month. (All-County Letter No. 93-30, May 10, 1993, interpreting Welfare and Institutions Code §§12300(g)(2), 12303.4, and 14132.95)

563-3B ADDED 7/06
Under PCSP, there is no NSI/SI distinction; all cases are eligible for a maximum of 283 hours.

NSI recipients may receive up to a total of 283 hours. [WIC 14132.95(g)]. If the case meets IHSS-R NSI criteria, only up to 195 hours can be authorized for protective supervision.

If 195 hours are authorized for protective supervision, the remaining service needs may be authorized, up to a maximum of 283 hours, for other PCSP services.

SI recipients may receive up to a total of 283 hours. [WIC 14132.95(g)].

(ACIN I-28-06, April 11, 2006, answer to question 15)

563-4
Grooming excludes cutting with scissors or clipping toenails. (§51350(f); see also Manual of Policies and Procedures (MPP) Handbook §30-780.2(f))

563-5
Menstrual care is limited to external application of sanitary napkin and cleaning. (§51350(g); see also Manual of Policies and Procedures (MPP) Handbook §30-780.2(g))

563-6
Paramedical services include catheter insertion, ostomy irrigation, and bowel program. (§51350(g); see also Manual of Policies and Procedures (MPP) Handbook §30-780.2(g). They also include the need for skin and wound care if decubiti have developed. (§51350(h); see also MPP Handbook §30-780.2(h))

563-7
Range of motion exercises shall be limited to the general supervision of exercises which have been taught to the beneficiary by a licensed therapist or other health care professional to restore mobility restricted because of injury, disuse or disease. Range of motion exercises shall be limited to maintenance therapy when the specialized knowledge or judgment of a qualified therapist is not required and the exercises are consistent with the beneficiary's capacity and tolerance. (§51350(h)(2); see also Manual of Policies and Procedures (MPP) Handbook §30-780.2(h)(2))

563-8
Following the *Arp* v. *Anderson* court case, counties were instructed that services provided by regional centers can no longer be considered an alternative resource under W&IC §12301(a) and MPP §30-763.61. PCSP and IHSS must be granted as though no services are being provided through a Regional Center. Determination of services to be

provided must be based strictly on an assessment of the developmentally disabled applicant. (All-County Letter No. 98-53, July 9, 1998; *Arp* v. *Anderson*, San Diego County Superior Court, No. 711204, Stipulation for Final Judgment, February 18, 1998)

564-1
The Personal Care Services Program (PCSP) provides personal care services to eligible Medi-Cal beneficiaries pursuant to Welfare and Institutions Code §14132.95 and Title 22, California Code of Regulations and is subject to all other provisions of Medi-Cal statutes and regulations. The program is operated pursuant to Manual of Policies and Procedures (MPP) Division 30. (MPP §30-700.2)

564-2 REVISED 8/05
Prior to August 1, 2004, individuals who qualified for both IHSS and PCSP were funded by PCSP. (Manual of Policies and Procedures (MPP) §30-700.3) The only exceptions are that the restaurant meal allowance (See Department of Social Services (DSS) All-County Letter (ACL) No. 93-21, March 16, 1993) and protective supervision (See DSS ACL No. 93-30, May 10, 1993) shall be funded from the residual IHSS Program.

Effective August 1, 2004, all IHSS Residual Program recipients who are eligible for federally funded full-scope Medi-Cal must move into either the IHSS Plus Waiver or PCSP. There will no longer be PCSP recipients who are eligible for the IHSS Residual Program.

Protective supervision, and cases that authorize Domestic and Related –Only services, will receive federal funding under PCSP. If there is a parent (for minor child) or spouse provider, or restaurant meal allowance or advance pay, the case is funded under the IHSS Plus Waiver. (All County Letter 05-05, June 2, 2005)

564-3
Under state law, the purpose of the IHSS Program is to provide those supportive services to Aged, Blind and Disabled (ABD) persons who are unable to perform the services themselves and "who cannot safely remain in their homes or abodes of their own choosing unless these services are provided." (W&IC §12300(a))

564-4
The CDHS has defined a "home" as real or personal property, fixed or mobile, located on land or water, in which a person or family lives. (§50044)

564-5
Under Assembly Bill (AB) No. 2779, PCSP eligibility was extended to individuals who were not receiving categorical aid payments.

When the individual who is now PCSP eligible has both a Medi-Cal and an IHSS share of cost (SOC), the individual shall not be financially disadvantaged under the state law. If the IHSS SOC is higher, the recipient must meet the lower Medi-Cal SOC. If the Medi-Cal SOC is higher, the recipient must meet the lower IHSS SOC, and the state will pay the amount between the Medi-Cal and the IHSS SOC.

(All County Welfare Directors Letter No. 99-13, March 29, 1999)

564-5A ADDED 5/05
All Medi-Cal eligibility determinations are to be completed following Medi-Cal rules. This includes Medi-Cal eligibility determinations for IHSS and PCSP recipients. (All County Welfare Director's Letter 04-27, August 30, 2004)

564-5B ADDED 8/05
All IHSS Residual Program recipients who are eligible for federally funded full-scope Medi-Cal must move into either the IHSS Plus Waiver or PCSP. There will no longer be PCSP recipients who are eligible for the IHSS Residual Program. However, WIC Section 12305.1 (which limits the SOC of PCSP recipients, who would otherwise be eligible for the IHSS Residual Program, to the lesser of the Medi-Cal or IHSS SOC) will still apply to PCSP cases and is being expanded in legislation to include IHSS Plus Waiver cases. This will be accomplished through a payment of Medi-Cal recognized expenses made by DSS to DHS on the first day of each month.

County Medi-Cal eligibility workers (EWs) must determine Medi-Cal eligibility and they will calculate the Medi-Cal SOC for the individual or family budget unit.. County social workers (SWs) must continue to calculate the IHSS SOC for PCSP and Waiver recipients and report this IHSS SOC to CMIPS so that CMIPS can calculate the amount of the Medi-Cal recognized expense payment to be made to DHS and to prepare the SOC Spenddown File for DHS at the beginning of each month.

The balance of the Medi-Cal SOC to be paid by the recipient should be equal to the amount that the IHSS SOC would have been had the transition to Medi-Cal not taken place.

(All County Letter 05-05, June 2, 2005)

566-2
In the PCSP, the following regulations apply to the evaluations of "personal care services":

(a) Personal care services include:

(1) Assisting with ambulation includes walking or moving around (i.e., wheelchair) inside the home, changing locations in a room, moving from room to room to gain access for the purpose of engaging in other activities. Ambulation does not include movement solely for the purpose of exercise.

(2) Bathing and grooming includes the cleaning of the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, reaching head and body parts for soaping, rinsing, and drying. Grooming includes hair combing and brushing, shampooing, oral hygiene, shaving and fingernail and toenail care.

(3) Dressing includes putting on and taking off clothes, fastening and unfastening garments and undergarments and special devices such as back of leg braces, corsets, elastic stockings/garments and artificial limbs or splints.

(4) Bowel, bladder and menstrual care includes assisting the person on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, assistance with using and emptying bedpans, ostomy and/or catheter receptacles and urinals, application of diapers and disposable barrier pads.

(5) Repositioning, transfer skin care, and range of motion exercises:

(A) This includes moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, chair, sofa, etc.; coming to a standing position; and/or rubbing skin and repositioning to promote circulation and prevent skin breakdown. However, if decubiti have developed, the need for skin and wound care is a paramedical service.

(B) Such exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking.

(6) Feeding, hydration assistance includes reaching for, picking up, grasping utensils and cups, getting food on utensils; bringing food, utensils, cups, to mouth; manipulating food on plate. It also includes cleaning face and hands as necessary following meal.

(7) Assistance with self-administration of medications consists of reminding the beneficiary to take prescribed and/or over-the-counter medications when they are to be taken and setting up Medi-sets.

(8) Respiration limited to nonmedical services such as assistance with self-administration of oxygen, assistance in the use of a nebulizer, and cleaning oxygen equipment.

(9) Paramedical services are defined in Welfare and Institutions Code §12300.1 as follows:

"(A) Paramedical services include the administration of medications, puncturing the skin or inserting a medical device into a body orifice, activities requiring sterile procedures, or other activities requiring judgment based on training given by a licensed health care professional.

"(B) Paramedical services are activities which persons could perform for themselves but for their functional limitations.

"(C) Paramedical services are activities which, due to the beneficiary's physical or mental condition, are necessary to maintain the beneficiary's health."

(§51183(a))

566-3
In the PCSP, the following regulations apply to the evaluation of "ancillary services":

(b) Ancillary services are subject to time per task guidelines when established in

MPP §§30-758 and 30-763.235(b) and 30-763.24 and are limited to the following:

(1) Domestic services are limited to the following:

(A) Sweeping, vacuuming, washing and waxing of floor surfaces.

(B) Washing kitchen counters and sinks.

(C) Storing food and supplies.

(D) Taking out the garbage.

(E) Dusting and picking up.

(F) Cleaning oven and stove.

(G) Cleaning and defrosting refrigerator.

(H) Bringing in fuel for heating or cooking purposes from a fuel bin in the yard.

(I) Changing bed linen.

(J) Miscellaneous domestic services (e.g., changing light bulbs and wheelchair cleaning, and changing and recharging wheelchair batteries) when the service is identified and documented by the case worker as necessary for the beneficiary to remain safely in his/her home.

(2) Laundry services include washing and drying laundry, and are limited to sorting, manipulating soap containers, reaching into machines, handling wet laundry, operating machine controls, hanging laundry to dry if dryer is not routinely used, mending or ironing, folding, and storing clothing on shelves or closets or in drawers.

(3) Reasonable food shopping and errands limited to the nearest available stores or other facilities consistent with the beneficiary's economy and needs; compiling a list; bending, reaching, and lifting; managing a cart or basket; identifying items needed; putting items away; phoning in and picking up prescriptions; and buying clothing.

(4) Meal preparation and cleanup includes planning menus, e.g., washing, peeling and slicing vegetables; opening packages, cans and bags; mixing ingredients; lifting pots and pans; reheating food; cooking; and safely operating stove, setting the table and serving the meals; cutting the food into bite-size pieces; washing and drying dishes, and putting them away.

(5) Assistance by the provider is available for accompaniment when the beneficiary's presence is required at the destination and such assistance is necessary to accomplish the travel limited to:

(A) Accompaniment to and from appointments with physicians, dentists and other health practitioners. This accompaniment shall be authorized only after county staff have determined that no other Medi-Cal service will provide transportation in the specific case.

(B) Accompaniment to the site where alternative resources provide IHSS to the beneficiary in lieu of IHSS. This accompaniment shall be authorized only after staff of the designated county department have determined that neither accompaniment nor transportation is available by the program.

(6) Heavy Cleaning which involves thorough cleaning of the home to remove hazardous debris or dirt.

(7) Yard hazard abatement which is light work in the yard which may be authorized for:

(A) Removal of high grass or weeds and rubbish when this constitutes a fire hazard.

(B) Removal of ice, snow or other hazardous substances from entrances and essential walkways when access to the home is hazardous

(§51183(b))

567-1 ADDED 5/05
It is the intent of the Legislature that the State Department of Health Services seek approval of a Medicaid waiver under the federal Social Security Act in order that the services available under Article 7 (commencing with Section 12300) of Chapter 3, known as the In-Home Supportive Services program, may be provided as a Medi-Cal benefit under this chapter, to the extent federal financial participation is available. The waiver shall be known as the "IHSS Plus waiver."

(Welfare and Institutions Code (W&IC) 14132.951(a))

567-2 ADDED 5/05
To the extent feasible, the IHSS Plus waiver described in subdivision (a) shall incorporate the eligibility requirements, benefits, and operational requirements of the In-Home Supportive Services program as it exists on the effective date of this section. The director shall have discretion to modify eligibility requirements, benefits, and operational requirements as needed to secure approval of the Medicaid waiver.

(Welfare and Institutions Code (W&IC) 14132.951(b))

567-3 ADDED 5/05
Upon implementation of the IHSS Plus waiver, and to the extent federal financial participation is available, the services available through the In-Home Supportive

Services program shall be furnished as benefits of the Medi-Cal program through the IHSS Plus waiver to persons who meet the eligibility requirements of the IHSS Plus waiver. The benefits shall be limited by the terms and conditions of the IHSS Plus waiver and by the availability of federal financial participation.
Upon implementation of the IHSS Plus waiver:(1) A person who is eligible for the IHSS Plus waiver shall no longer be eligible to receive services under the In-Home Supportive Services program to the extent those services are available through the IHSS Plus waiver.
(2) A person shall not be eligible to receive services pursuant to the IHSS Plus waiver to the extent those services are available pursuant to Section 14132.95.
(W&IC §14132.951(c) and (d))

567-3A ADDED 11/05
Services provided under the IHSS Plus Waiver shall be rendered, under the administrative direction of the State Department of Social Services, in the manner authorized in Article 7 (commencing with Section 12300) of Chapter 3, for the In-Home Supportive Services program. (W&IC §14132.951(e))

567-4 ADDED 5/05
Notwithstanding the Administrative Procedure Act, Chapter3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title2 of the Government Code, the department may implement the provisions of this section through all-county welfare director letters or similar publications. Actions taken to implement, interpret, or make specific this section shall not be subject to the Administrative Procedure Act or to the review and approval of the Office of Administrative Law. Upon request of the department, the Office of Administrative Law shall publish the regulations in the California Code of Regulations. All county welfare director letters or similar publications authorized pursuant to this section shall remain in effect for no more than 18 months.
The department may also adopt emergency regulations implementing the provisions of this section. The adoption of regulations implementing this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. Any emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and shall remain in effect for no more than 18 months by which time final regulations shall be adopted.
(W&IC §14132.951(h)

567-5 ADDED 5/05
(i) In the event of a conflict between the terms of the IHSS Plus waiver and any provision of this part or any regulation, all-county welfare directors letters or similar publications adopted for the purpose of implementing this part, the terms of the waiver shall control to the extent that the services are covered by the waiver. If the department determines that a conflict exists, the department shall issue updated instructions to counties for the purposes of implementing necessary program changes. The department shall post a copy of, or a link to, the instructions on its Web site.
(W&IC §14132.951(i))

567-6 ADDED 5/05
All Medi-Cal eligibility determinations are to be completed following Medi-Cal rules. This

includes Medi-Cal eligibility determinations for IHSS and PCSP recipients. (All County Welfare Director's Letter 04-27, August 30, 2004)

567-6A ADDED 8/05
Medi-Cal eligibility determinations and redeterminations are to be performed on all applications received by the county requesting in-home services and existing in-home service for persons who are not also eligible for SSI/SSP or other Medi-Cal linked cash-based assistance. These determinations/redeterminations are to be performed by Medi-Cal eligibility workers using Medi-Cal rules, Medi-Cal forms, and notices of action.

Individuals must be determined eligible for whatever Medi-Cal program is appropriate (e.g., Section 1931(b), Aged and Disabled Federal Poverty Level, Pickle, Medically Needy, 250 percent Working Disabled, etc) before a referral is forwarded to the IHSS unit for a needs assessment.

(All County Welfare Director's Letter 05-21. June 13, 2005).

567-7 ADDED 8/05
IHSS Plus Waiver eligibility is restricted to individuals who are requesting or receiving in-home care and who have been determined eligible for federally funded full-scope Medi-Cal and who:

- Receive personal care; protective supervision; domestic and related services; heavy cleaning; yard hazard abatement; or teaching and demonstration, when any of the services are provided by a spouse of the recipient or parent of a minor child recipient as allowed under MPP §§30-763.41 and .45;
- Receive Restaurant Meal Allowance; and/or
- Receive Advance Payment for in-home services.

If <u>any</u> of the above components exist in a case, the entire case will be covered under the IHSS Plus Waiver.

(All County Letter 05-05, June 2, 2005; All County Welfare Director's Letter 05-21, June 13, 2005)

567-8 ADDED 8/05
All IHSS Residual Program recipients who are eligible for federally funded full-scope Medi-Cal must move into either the IHSS Plus Waiver or PCSP. There will no longer be PCSP recipients who are eligible for the IHSS Residual Program. However, WIC Section 12305.1 (which limits the SOC of PCSP recipients, who would otherwise be eligible for the IHSS Residual Program, to the lesser of the Medi-Cal or IHSS SOC) will still apply to PCSP cases and is being expanded in legislation to include IHSS Plus Waiver cases. This will be accomplished through a payment of Medi-Cal recognized expenses made by DSS to DHS on the first day of each month.

County Medi-Cal eligibility workers (EWs) must determine Medi-Cal eligibility and they will calculate the Medi-Cal SOC for the individual or family budget unit.. County social workers (SWs) or other designated county staff must continue to calculate the IHSS SOC for PCSP and Waiver recipients and report this IHSS SOC to CMIPS so that CMIPS can calculate the amount of the Medi-Cal recognized expense payment to be

made to DHS and to prepare the SOC Spenddown File for DHS at the beginning of each month.

The balance of the Medi-Cal SOC to be paid by the recipient should be equal to the amount that the IHSS SOC would have been had the transition to Medi-Cal not taken place.
(All County Letter 05-05, June 2, 2005 and 05-05 errata July 20, 2005)

567-9 ADDED 11/05
Effective August 1, 2004, under the IHSS Plus Waiver program, caregiver wages paid to a parent for providing in-home services to a minor child are exempt. So are wages paid to a spouse who provides in-home services to his/her spouse. Also exempt under the IHSS Plus Waiver program are a restaurant meal allowance or advance pay made to a recipient to pay the in-home services caregiver. (ACWDL 05-29, August 29, 2005)

567-10 ADDED 7/06
A parent can work out of the home and still be an IPW provider as long as they are not working full-time. MPP 30-763.451(a) requires that to be a paid provider, the parent has left full-time employment or is prevented from obtaining full-time employment because of the need to provide in home supportive services to the child.

Two parents who both work full-time cannot be paid for services in the IPW during the hours they are home in the morning and evening. In order for parents to be paid providers, they must meet the criteria in MPP 30-763.45. MPP 30-763.451(a) requires that the parent has left full-time employment or is prevented from obtaining full-time employment because of the need to provide IHSS to the child.

(ACIN I-28-06, April 11, 2006, answers to questions 6 and 8)

567-11 ADDED 7/06
ID Waiver recipients are eligible for the IPW as long as the recipient meets all IPW eligibility criteria. ID Waiver cases were previously served in the PCSP, as PCSP is a Medi-Cal benefit. With the implementation of the IPW (also a Medi-Cal benefit) on August 1, 2004, these cases may now be covered under either PCSP or the IPW, depending on the eligibility criteria. If ID Waiver cases meet IPW criteria (i.e. parent or spouse provider, receives advance pay or restaurant meal allowance), then the case would be served under the IPW. Spouses and parents of minor children, therefore, can be paid providers under the IPW, regardless of how the recipient qualified for federally funded full-scope Medi-Cal.

Parents of minor children whose Medi-Cal eligibility is through the ID Waiver are eligible to provide all authorized services, including Protective Supervision under the IPW. Persons whose Medi-Cal eligibility is through the ID Waiver are eligible to receive Protective Supervision under PCSP also, as long as the parent or spouse is not the provider.

(ACIN I-28-06, April 11, 2006, answers to questions 10 and 11)

567-12 ADDED 7/06
Up to eight hours of respite care is offered under the IPW for periods when the parent(s)

must be absent to perform errands related to care of recipient's siblings.

(ACIN I-28-06, April 11, 2006, answer to question 14)

567-13 ADDED 7/06
Under the IHSS Plus Waiver, NSI recipients may receive up to a total of 195 hours, including any needed protective supervision. (WIC 12303.4(a), MPP 30-765.12). The entire 195 hours can be for protective supervision if no other needed services are paid for by IHSS.

SI recipients may receive up to a total of 283 hours, including any needed protective supervision. (WIC 12303.4(b), MPP 30-765.11)

(ACIN I-28-06, April 11, 2006, answer to question 15)